Fact Sheets on New Federally Approved Evidence-Based Home Visiting Models
January 2013

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Fact Sheet on Child FIRST

Model Developer: Bridgeport Hospital is the home and fiduciary – the model began as a collaboration Bridgeport health, education, and social service providers.

Goal or Purpose and Basic Description: The goal of Child FIRST is to decrease the incidence of emotional and behavioral disturbance, developmental and learning problems, and abuse and neglect among high-risk young children and their families. The Child FIRST model is based on the most current research on brain development, which shows that extremely high-stress environments (including poverty, maternal depression, domestic violence, abuse and neglect, substance abuse, and homelessness) are "toxic" to the developing brain of the young child. The presence of a nurturing, consistent, and contingent parent-child relationship is able to buffer and protect the brain from these damaging insults.

Target Population / Eligibility Requirements: Child FIRST provides services to pregnant women and families with children from birth to age 6 years, in cases in which the child has emotional, behavioral, or developmental concerns or the family faces multiple risks that are likely to lead to negative child outcomes. Families are served without regard for ability to pay, legal status, or number of children in the family.

Home Visitor Qualifications and Roles: There are two members of the home visiting team:

- **A Master's level Mental Health/Developmental Clinician** who provides a dyadic, two-generation psychotherapeutic intervention and parent guidance, and
- **A Bachelor's level Care Coordinator** who connects children and families with comprehensive community-based services and supports.

Curriculum: The Child FIRST intervention consists of the following components:

- **Intensive outreach** to engage hard-to reach families
- **Comprehensive assessment** of the child and all members of the family
- Partnership with the family to develop a well-coordinated, **comprehensive family-driven plan of supports and services** for all family members
- Home-based **parent guidance and psychotherapeutic intervention** using an adaptation of Child-Parent Psychotherapy, especially for families with multiple challenges, like depression, domestic violence, and abuse and neglect
- **Consultation in the early care and school settings** for children with challenging behaviors
- **Care coordination and case management** to provide hands-on assistance connecting all family members with community-based services and supports

Intensity (recommended frequency and duration of visits): Team works together with the family one or more times per week, over an average period of six to twelve months. Duration of involvement is determined by family needs and priorities.

Number of sites, number of states: Currently, there are six fully trained program sites (Cohort 1) and four which are participating in the Learning Collaborative (Cohort 2). All are in Connecticut.

Demonstrated Outcomes:
A randomized, controlled trial demonstrated that the Child FIRST intervention was statistically significant and clinically effective when compared to Usual Care controls at 12 month follow-up:

- Child FIRST children were significantly less likely to have language problems (odds ratio=4.2).
- Child FIRST children were significantly less likely to have aggressive and defiant behaviors
- (odds ratio=4.8).
- Child FIRST mothers had significantly lower levels of depression and mental health problems.
- Child FIRST families were significantly less likely to be involved with child protective services (by parent report)
- (odds ratio=4.1).
- Child FIRST family members had a marked increase in access to services (91% vs. 33%).

At 3 year follow up:

- Child FIRST families were significantly less likely to be involved with child protective services (odds ratio=2.1).

The results of the randomized trial have been published in Child Development in January/February 2011.

Sources:

http://www.childfirst.net/

http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=42&mid=2

Fact Sheet on Early Intervention Program for Adolescent Mothers

Model Developer: EIP was implemented as a collaborative demonstration project by the University of California at Los Angeles (UCLA) School of Nursing and the San Bernardino County Department of Public Health, Division of Community Health Services.

Goal or Purpose and Basic Description: EIP was designed to help young mothers gain social competence and achieve program objectives. The construct of social competence was conceived to have two facets: internal and external. EIP aimed to improve internal competence—the mother's ability to manage her inner world—through training in self-management skills and techniques for coping with stress and depression. EIP aimed to improve external competence—the mother's ability to interact effectively with partners, family, peers, and social agencies—through training in communication and social skills.

Target Population / Eligibility Requirements: The Early Intervention Program (EIP) targeted pregnant Latina and African American adolescents who were referred to the county health department for public health nursing care. The women were eligible for EIP if they were 14 to 19 years of age; no more than 26 weeks gestation; pregnant with their first child; and planning to keep the infant. Expectant mothers who were chemically dependent or had serious medical or obstetric problems were ineligible.

Home Visitor Qualifications: Specially trained public health nurse

Role of the Home Visitor: Public health nurses delivered EIP services using a case management approach, with one nurse providing continuous care to her assigned caseload. During home visits, public health nurses used a variety of teaching methods to cover five main content areas: health, sexuality and family planning, maternal role, life skills, and social support.

Curriculum: During home visits, public health nurses used a variety of teaching methods to cover five main content areas: (1) health, (2) sexuality and family planning, (3) maternal role, (4) life skills, and (5) social support systems.

Prenatal visits focused on use of prenatal heath care, preparation for childbirth, and self-care during pregnancy. In addition, the public health nurses conducted four classes focused on the transition to motherhood, fetal development, parent-child communication, and maternal health. The courses used several teaching strategies, including group discussion, role play, decision-making exercises, communication games, and maternal-fetal interactive activities.

During the postpartum visits, mothers received information on family planning, infant care, and well-baby health care. Nurses also delivered interventions designed to help mothers develop communication skills and learn how to assess their infants' needs, respond to infant distress, and interact reciprocally with their infants. The public health nurses also counseled adolescents on maternal role issues (such as caretaking and fetal and infant development); education attainment; substance use; and mental health issues, such as handling emotions. They also initiated referrals as needed for mental health counseling, family planning, and child care. Public health nurses performed videotaped instruction and feedback (videotherapy) at regular intervals using a standardized protocol that involved videotaping the mother performing a teaching task with her infant and subsequently soliciting the mother's opinion about the quality of the interaction.

Intensity (recommended frequency and duration of visits): EIP includes home visits from mid-pregnancy through the child's first year of life. Participants received approximately 4 prenatal classes and approximately 17 home visits.

Demonstrated Outcomes: This program model meets the DHHS criteria because there is at least one high or moderate quality impact study with favorable, statistically significant impacts in at least two of the eight outcome domains. At least one of these impacts is from a randomized controlled trial and has been published in a peer-reviewed journal. At least one of the favorable impacts from a randomized controlled trial was sustained for at least a year after program enrollment. Early program outcomes indicate reduced premature birth rates for both groups compared with national data on adolescent mothers, and fewer days of infant hospitalization during the first 6 weeks postpartum for the EIP participants.

Sources:

http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=39&mid=2

http://www.childtrends.org/Lifecourse/programs/EarlyInterventionProgramForAdolescentMothers.htm

Fact Sheet on The Early Start (New Zealand)

Model Developer: a consortium of Christchurch based organizations developed an intensive home visiting service that came to be known as Early Start. The initial consortium of providers included: The Christchurch Health and Development Study; the Family Help Trust; the Plunket Society; the Pegasus GP group; and Māori representatives. Today Early Start is contracted to and is receiving funding from the Ministry of Social Development, Canterbury DHB, Department of Child, Youth and Family and the Christchurch City Council to work with 251 families caring for 439 children.

Goal or Purpose and Basic Description: Early Start aims to create a collaborative, problem-solving partnership between the home visitor and family to maximize child health, increase child and family well-being, build strengths, and eliminate deficiencies. Early Start recognizes that child well-being can occur only through the more general health and well-being of the family, although the target child is treated as the primary focus of services.

Target Population / Eligibility Requirements: Early Start targets at-risk families with newborn children up to age 5. Early Start uses a three-stage eligibility determination process. First, Early Start administers a short risk assessment containing items on maternal age, extent of family support, whether the pregnancy was planned or unplanned, substance abuse, family violence, and child abuse and neglect. Any family with two or more risk factors continues to the next stage of the process. Second, families enroll in Early Start for a one-month assessment period to become acquainted with the program and so Early Start can learn about the family. Third, families complete an in-depth needs assessment based on a modified version of the Kempe Family Stress Checklist and are fully enrolled in the program for longer-term services.

Home Visitor Qualifications: The service is provided by trained Family Support Workers who have professional qualifications in the areas of nursing, social work, teaching, or an allied profession.

Role of the Home Visitor: Early Start Family Support Workers/Whanau Awhina work with client families using a collaborative, problem solving and solution focused approach, finding a balance between:

- Family strengths and family challenges
- Family generated goals and agency generated goals

Curriculum: Early Start provides services through home visitation. All Early Start families receive services based on four established curricula:

1. Partnership in Parenting Education (PIPE) “Listen, Love, Play,” which focuses on listening, trust, language, problem solving, feelings, and how babies learn
2. Triple P (Positive Parenting Program), which focuses on positive parenting practices and means to address childhood behavior problems
3. Getting Ready for School focused on 4 year olds
4. Incredible Years

Families are offered several additional services based on need:

- Infant and child safety awareness
- Linkages to supportive services in the community, including budget, health, and relationship services
- Advice and support concerning healthy lifestyle choices, including family and child nutrition
- Household and time management

Intensity (recommended frequency and duration of visits): The extent of service delivery depends on the level of family need and varies from Level 1 (weekly home visits) to Level 4 (3-monthly home visits).

Number of sites, number of states: Appears to be only in New Zealand, in Christchurch.

Demonstrated Outcomes: A randomized control trial was conducted with follow up studies every few years. The weight of the evidence suggests Early Start has beneficial effects for a series of child related outcomes spanning health, pre-school education, service utilization, child abuse, parenting, and child behavior. There was consistent evidence showing the provision of Early Start did not have any benefit for a wide range of parental and family outcomes.

The findings of the randomized control trial show that, up to the three year follow-up, children in Early Start received a number of benefits including: greater use of health services; reduced rates of hospital attendance for childhood accidents; greater use of preschool education and dental services; lower rates of parental reported childhood physical abuse; less punitive and more positive parenting; and lower rates of childhood problem behaviors. By the nine year follow-up, there was evidence to show the children from families provided with Early Start had:

- Rates of hospital attendance for childhood accidents approximately 33% lower than those for the Control group
- Rates of parental reported physical child abuse more than 50% lower than those for the Control group
- More positive mean scores on measures of punitive parenting and parenting competence
- Lower mean scores on measures of parental reported child behavior problems.

Sources:

http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=38&mid=2

http://www.earlystart.co.nz/

http://www.earlystart.co.nz/pdf/evalreport2012.pdf

Fact Sheet on Fact Sheet on Family Check-Up

Model Developer: The University of Oregon Child and Family Center Family Check-Up Institute, Eugene, Oregon. http://www.uoregon.edu/~cfc/educa-training.htm

Goal or Purpose and Basic Description: Family Check-Up is designed as a preventative program to help parents address typical challenges that arise with young children before these challenges become more serious or problematic. The Family Check-Up is a comprehensive family assessment that includes: a home visit, observations of family interactions; interviews with family members; a school assessment; 1-2 follow-up meetings that provide feedback, collaboration with parents to evaluate family needs, and a menu of intervention options, including continued therapy at the Child and Family Center (CFC).

Family services determined by the Family Check-Up can include: individual interventions with children and adolescents (counseling, therapy, advocacy within a mental health delivery system and individual interventions, typically combined with family therapy); family therapy and support; parenting skills and support; comprehensive child assessments (collaboration with families, teachers, and other individuals involved in children's lives; in-depth exploration of children's competencies, areas of concern, and overall adaptation; psychological and neuropsychological testing for children and adolescents, if indicated; and support when there are neuropsychological difficulties or behavioral and emotional disorders); and child-centered skill enhancement (Social skill development, anger management and self-control).

Target Population / Eligibility Requirements: - families with risk factors including: socioeconomic; family and child risk factors for child conduct problems; academic failure; depression; and risk for early substance use. Families with children age 2 to 17 years old are eligible for Family Check-Up.

Home Visitor Qualifications: - parent consultant who has been trained in the program model and has an advanced degree in psychology or a related field.

Role of the Home Visitor: Family Check-Up consists of three home visits with a parent consultant. After the three home visits, the parent consultant makes recommendations for a family-based intervention tailored to the needs of the family, such as parent management training, preschool consultation, or community referrals.

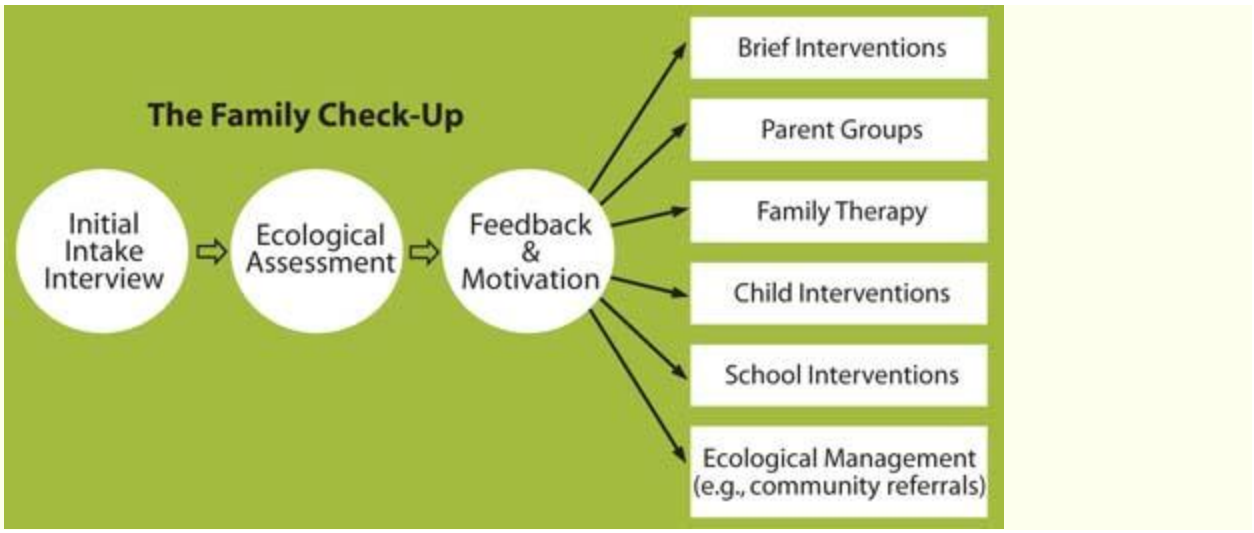
Curriculum: - Following these three sessions, the Everyday Parenting curriculum provides a basis for more intensive parenting support. The FCU model involves yearly “check-ups,” which provide clinicians with the opportunity to track family and child behavior over time and continue to motivate families to change persistent areas of difficulty.

Required Training and Vendor: The Child and Family Center, Eugene, Oregon conducts an annual series of intensive four-day training workshops for professionals interested in learning more about CFC’s ecological model of intervention, called EcoFIT, and learning to use the Family Check-Up. Cost is $1,000 per trainee;

Intensity (recommended frequency and duration of visits): Three home visits, followed by individualized services and an annual review.

Number of sites, number of states: Apparently one clinic in Eugene, Oregon.

Unique Features:



Each check-up includes: an Initial interview, Ecological assessment, Feedback session and the selection of Services. The Service menu includes Brief family-centered interventions, Parent groups, Family therapy, Child interventions, School-based interventions and Ecological management and advocacy.

Demonstrated Outcomes: Favorable results have been found in (1) child development and school readiness and (2) positive parenting practices.

Sources:

MIEC implementation Plan Guidance
Home Visiting Evidence of Effectiveness Database
http://pages.uoregon.edu/cfc/aboutus01.htm

Fact Sheet on Healthy Steps

Model Developer: Boston University School of Medicine, Department of Pediatrics

Goal, Purpose and Description: Healthy Steps is an initiative that emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to age 3. Each Healthy Steps team includes a pediatric or family clinician and a Healthy Steps Specialist, who enhances the information and services available to parents.

Healthy Steps can be implemented by any pediatric or family medicine practice. Residency training programs can also implement Healthy Steps. Community health organizations, private practices, hospital based clinics, child health development organizations, and other types of clinics can also become Healthy Steps sites if a health care clinician is involved and the site is based in or linked to a primary health care practice.

The Healthy Steps national office requires that, at a minimum, participating practices offer the following services: (1) home visits offered as soon after a newborn is discharged from the hospital and at key developmental stages; (2) well-child visits with a clinician and Healthy Steps Specialist; (3) child development and family health checkups (including formal developmental screens); (4) a child development telephone information line; (5) referrals for children (such as speech or hearing specialists) and parents (such as maternal depression counseling); (6) age-appropriate books for children; and (7) written materials for parents on topics such as toilet training, discipline, and nutrition. In addition, participating practices might offer parent support groups. To use the Healthy Steps name and logo, a site must Offer at a minimum these Healthy Steps components: home visits, child development checkups (including formal developmental screen), child development telephone information line, and Healthy Steps parent information materials.

Target Population / Eligibility Requirements: Healthy Steps is designed for parents with children from birth to age 30 months. Any family served by the participating practice or organization can be enrolled in Healthy Steps.

Home Visitor Qualifications: The Healthy Steps Specialist can be a nurse, child development specialist, or social worker.

Role of the Home Visitor: The Healthy Steps Specialist provides an effective link between the family and the pediatric and family practice. Healthy Steps Specialists offer mothers and fathers the added expertise, time, and personal support that they want to facilitate their child's healthy growth and development. During home visits, the Healthy Steps Specialists address behavioral and developmental issues and share information with parents about ways they can help foster their children's needs.

Required Training and Vendor: Initial training for the participating pediatric practice is provided on-site by faculty from Boston University School of Medicine. The Healthy Steps Training Institute lasts for three days and the cost ranges from $10,000 to $15,000. Additional continuing education materials and programs are available on DVD. As an alternative, continuing medical education credits for physicians and continuing education credits for Specialists can be obtained by completing the training materials provided in the healthy Steps Multimedia Training and Resource Kit (cost: $99).

Healthy Steps Specialists are required to have a minimum of ten hours of continuing education obtained by attendance at a Healthy Steps Training Institute or in an on-site training program organized by the practice using the Healthy Steps Multimedia Training and Resource Kit.

Intensity (recommended frequency and duration of visits) - Healthy Steps can be implemented at different levels of intensity: (1) high-intensity sites offer five home visits at birth–1 month, 9–12 months, 18 months, 24 months, and 30 months; (2) medium-intensity sites offer three home visits at birth–1 month, 9–12 months, and 18 months; and (3) low-intensity sites offer two home visits at birth–1 month and 9–12 months.

Supervision: provided by the practice physicians who have completed Healthy Steps training

Number of sites, number of states - Healthy Steps programs are located in 19 states: Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Kansas, Massachusetts, Michigan, Mississippi, Missouri, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, and Texas.

Annual Cost or Cost Per Family: depends upon several parameters unique to each practice.

Demonstrated outcomes: The program focuses on the following outcomes: (1) child development and school readiness; and (2) positive parenting practices.

Fact Sheet on Home Instruction Program for Preschool Youngsters (HIPPY)

Model Developer: Home Instruction for Parents of Preschool Youngsters (HIPPY) USA is the national office for the network of state coordinating offices and local HIPPY programs in the United States.

Goal, Purpose and Description: HIPPY) aims to promote preschoolers' school readiness by supporting parents in the instruction provided in the home. The HIPPY program offers weekly activities for 30 weeks of the year, alternating between home visits and group meetings (two one-on-one home visits per month and two group meetings per month).

The HIPPY model includes: a developmentally appropriate curriculum; role play as the method of teaching; staffed by home visitors from the community who are supervised by a professional coordinator; and with home visits interspersed with group meetings as the delivery methods. A model HIPPY site serves up to 180 children with one coordinator and 12-18 part-time home visitors.

Target Population / Eligibility Requirements: HIPPY serves parents with children ages 3 through 5. HIPPY is designed for parents who have doubts about or lack confidence in their ability to instruct their children and prepare them for school. Frequently, these parents had negative school experiences themselves or have limited formal education, limited financial resources, or other risk factors. HIPPY sites are encouraged to offer the three-year program serving three to five year olds, but may offer the two-year program for four to five year olds. HIPPY USA requires that all sites implement a program for 5-year-olds.

Home Visitor Qualifications: The home visiting paraprofessionals are typically drawn from the same population that is served by a HIPPY site and parents in the program. HIPPY USA encourages home visitors to serve in that capacity for no more than three years (that is, while they have children who are old enough to participate in the program.)

Role of the Home Visitor: The home visitors role-play the activities with the parents and support each family throughout their participation in the program. During each visit, the home visitor provides the parent with the tools and materials that enable the parent to work directly with their child on developmentally appropriate, skill building activities. Another important aspect of the home visit is the transfer (home visitor to parent) of early childhood development concepts and terminology that increase the parent's ability to observe and understand their child's learning process.

Curriculum: The HIPPY Curriculum, designed for children ages three, four, and five, contains 30 weekly activity packets, nine storybooks and a set of 20 manipulative shapes for each year. In addition to these basic materials, supplies such as scissors and crayons are provided for each participating family.

Required Training and Vendor: The coordinator is required to successfully complete the entire week of the HIPPY pre-service training before starting a new program, or taking on the coordination of an existing program. The HIPPY pre-service training is five days in length and covers all aspects of administering a HIPPY program. It is also recommended that the HIPPY coordinator's supervisor and/or another agency administrator attend for at least the first two days of Pre-service training.

Home Visitors initially receive training in the use of the curriculum during an Initial Site Visit conducted by a national HIPPY trainer. Thereafter, they receive weekly HIPPY training from their coordinator, which periodically should include professional skill development.

Intensity (recommended frequency and duration of visits) – HIPPY USA recommends that activities be offered weekly and alternate between group meetings and home visits. It also recommends that group meetings last two hours. No information is available about the recommended length of the home visits.

Supervision: Each HIPPY program is supervised by a professional coordinator whose primary responsibilities are recruiting parents, hiring and training home visitors, organizing parent group meetings, and developing enrichment activities. The coordinator and the home visitors meet weekly to role play the materials, to discuss the previous week's activities, and to share experiences and problems.

Number of sites, number of states - HIPPY programs are located in 22 states and the District of Columbia. (The states are Alabama, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Illinois, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Nevada, New Jersey, New York, Ohio, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin).

Ten states have coordinating offices: Alabama, Arkansas, Colorado, Florida, Hawaii, Louisiana, Maryland, Nevada, Rhode Island, and Texas. State coordinating offices provide assistance and support to new and existing HIPPY programs.

Annual Cost or Cost Per Family - The average program costs to the implementing agency or organization are approximately $1,837 per child per year. This range is based on an average program size of 60 families in the first year and 120 families in the second year, a full-time coordinator, and one paraprofessional for each group of 12 families. Costs include staff salaries, curriculum materials, fees for training and technical assistance, program development and other direct costs.

Unique Features HIPPY USA has developed an adaptations document that reflects the most common changes that are implemented and that still allow for effective service delivery. The document, which is distributed to all programs, shows what adaptations are acceptable and under what specific circumstances they are acceptable, plus guidelines for reporting and implementing.

Parents are strongly encouraged to attend the bi-weekly group meetings. The first hour of the group meeting is used to discuss the previous week's activities and to role play the subsequent week's activity. In the second hour, parents engage in enrichment activities, which involve issues related to parenting, employment, school/community/social services, and personal growth. The objective for the enrichment activity (topics are selected by the parents) is to provide the training and knowledge that will allow parents to be more effective as parents and as members of the community, more self-assured and more self-reliant. Child care provided during the group meeting allows for social interactions for the children.

Demonstrated outcomes: HIPPY is designed to (1) improve language development, problem solving, logical thinking, and perceptual skills; and (2) enhance social, emotional, and physical (fine and gross motor skills) development. Favorable evidence was found in child development and school readiness and positive parenting practices.

Fact Sheet on Oklahoma Community-Based Family Resource and Support Program

Model Developer: The program was administered by the Oklahoma State Department of Health in response to the Child Abuse Prevention and Treatment Act amendments of 1996, which allocated funding for state CBFRS programs to reduce the incidence of child abuse and neglect through a wide range of services.

Goal or Purpose and Basic Description: Oklahoma's CBFRS program was developed to improve the health and development outcomes of mothers and their infants. The model targeted first-time mothers and was designed to provide an intensive level of service through weekly and biweekly visits. Based on research suggesting that home visiting provided by professionals as opposed to paraprofessionals might provide more positive impacts, the program developers decided to use professionals in the field of child development to provide the home visits.

Target Population / Eligibility Requirements: Oklahoma's CBFRS program targeted first-time mothers living in rural counties.

Home Visitor Qualifications: Oklahoma's CBFRS program provided the home visitors with more than 40 hours of preservice training as well as ongoing in-service training.

Intensity (recommended frequency and duration of visits): Home visits—offered weekly or biweekly—began before 28 weeks gestation and continued to the child's first birthday. The content and the intensity of the program varied depending upon the stage of the intervention and the age of the child. During pregnancy, participants were visited weekly the first month of the program, followed by biweekly visits until the child's birth up to eight prenatal visits. After the child's birth, home visits occurred weekly during the first three months of the child's life and biweekly for the next three months, for a total of 18 visits. Between six months and one year, biweekly visits continued for the remainder of the program for a total of 12 visits. Each visit was about an hour in length.

Demonstrated Outcomes: Taking into account all of the review results as of January 2012, which include all high- or moderate-quality impact studies for this program model regardless of publication venue, the Oklahoma CBFRS program model had favorable impacts in the maternal health and positive parenting practices domains and no unfavorable or ambiguous impacts in other domains examined by the HomVEE review. Oklahoma CBFRS had favorable impacts on the mother's use of birth control, incidence of pregnancy since the birth of her first child, and incidence of pregnancy at the time of the 12-month interview for the study. At the 12-month interview, Oklahoma CBFRS also had positive impacts on a home safety outcome and on the acceptance subscale of the home environment assessment.

Sources:
http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=50&mid=2
http://homvee.acf.hhs.gov/CBFRS_Short_Report.pdf

Fact Sheet on Play and Learning Strategies Infant

Model Developer: The Children's Learning Institute at the University of Texas Health Science Center

Goal or Purpose and Basic Description: PALS was developed to facilitate parents' mastery of specific skills for interacting with their infants and toddlers. It is designed as a preventive intervention program to strengthen the bond between parent and child and to stimulate early language, cognitive, and social development.

Target Population / Eligibility Requirements: Two versions of the program exist: PALS Infant curriculum and PALS Toddler curriculum. PALS Infant curriculum targets children 5 months to 1 year and their families.

Home Visitor Qualifications: Parent educators who have at minimum an associate's degree in early childhood (or a related field) or work experience commensurate with education. PALS Infant parent educators are supervised by a person with at least a bachelor's degree in early childhood education, or a related field, and have three to five years experience in parent education.

Curriculum: PALS includes one-on-one home visits between a trained parent educator and a parent. The PALS curriculum was designed as a preventive intervention program to strengthen the bond between parent and child and stimulate early language, cognitive, and social development. PALS uses videotaped examples of real mothers and children to demonstrate each concept and allow the parent to critique these examples before practicing new skills with her own child. Guided practice opportunities during each session help parents move from watching, listening, and talking, to doing. The program is designed to be facilitated by a trained parent educator who presents each session to the parent(s) and coaches the parent(s) in utilizing the specific techniques. The PALS Infant curriculum consists of 10 sessions and is appropriate for parents of infants from about age five months to one year. Session topics include: attending to babies' and toddlers' communicative signals, responding appropriately to children's positive and negative signals, supporting infants' and toddlers' learning by maintaining their interest and attention rather than redirecting or over stimulating, introducing toys and activities, stimulating language development through labeling and scaffolding, encouraging cooperation and responding to misbehavior, and incorporating these strategies and supportive behaviors throughout the day and during routine activities such as mealtimes, dressing, and bathing, as well as at play times. Throughout the program there is also an emphasis on educating parents about typical behaviors to expect from children at different ages.

Required Training and Vendor: Staff at the Children's Learning Institute provide required PALS Infant training either at the Children's Learning Institute in Houston, Texas, or on site at local implementing agencies. PALS Infant training is 2.5 days. Weekly group supervision sessions serve as a forum for ongoing training of PALS Infant content and coaching strategies. Ongoing training for supervisors is available from the Children's Learning Institute upon request.

Intensity (recommended frequency and duration of visits): The program is designed for children 5 months to 1 year. PALS Infant consists of 10 sessions, each of which lasts about 90 minutes.

Number of sites, number of states: The Infant and Toddler versions of the PALS curriculum have been implemented as part of intervention research studies and grant-funded service programs at numerous sites across the United States (Florida, Georgia, Alabama, Tennessee, Kentucky, Indiana, Michigan,

Maryland, New York, Washington, D.C., Pennsylvania, Virginia, Minnesota, Kansas, Arkansas, Wyoming, Washington, California, and Arizona) and many sites across the State of Texas.

Demonstrated Outcomes: The effectiveness of the PALS program in changing mothers' behaviors and enhancing their children's development was initially documented through a randomized control design research study (funded by NIH grant HD36099) that included over 240 families (see Publications for more details). Following the initial positive results, in which increases in maternal responsiveness behaviors and children's language and social interaction were documented, the PALS curriculum has been adapted for use with a variety of populations and in group settings as well as the original home-based individual format (see Projects and Locations for more details).

Sources:
http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=49&mid=2
http://www.childrenslearninginstitute.org/our-programs/program-overview/PALS/default.html
http://homvee.acf.hhs.gov/PALS_Infant_Short_Report.pdf